**IMPORTANT NOTES:**

* **Visit Daiichi Sankyo AccessCentral4U for additional resources, such as prior authorization checklist, enrollment form, etc.**
* **Please review the health plan's instructions to determine whether additional enclosures, such as forms, chart notes, test results, or peer-reviewed literature, may also be necessary**
* **Use of the information in this letter does not guarantee coverage. It is not intended to be a substitute for, or an influence on, the independent medical judgment of the physician**
* **REMINDER: Translate this sample letter onto your physician's letterhead before printing**

**SAMPLE LETTER OF MEDICAL NECESSITY**

[Date]

[Name]

[Insurance Company]

[Insurance Company Address]

[City, State, ZIP Code]

[Fax Number]

**ATTN: Prior Authorizations/Appeals Department**

Re: Coverage of [PRODUCT Name]

[Patient First and Last Name]

[Insurance Policy Number]

[Insurance Group Number]

[Patient Date of Birth]

Diagnosis: [Diagnosis and Code]

To whom it may concern:

The purpose of this letter is to substantiate the medical necessity of [PRODUCT Name] for [Patient Name]. [Insert information on PRODUCT Name, such as indication and efficacy data]. Treatment with [PRODUCT Name] is medically necessary based on [Patient Name]’s confirmed diagnosis of [Disease State], [Insert other reasons such as severity of symptoms, impact to quality of life, or ineffective response to prior treatments].

[Patient Name]’s pertinent medical information history is below:

[Insert description, below:

* Diagnosis date and details as well as current medical conditions
* Test results
* Any previous and/or current treatment regimens
* Observed outcomes with any past treatments
* Desired treatment goals
* Patient’s likely prognosis without treatment with [PRODUCT Name]
* Clinical rationale explaining why alternative treatment is suboptimal or inappropriate (eg, efficacy observed in clinical trials, contraindications)]

The information I have provided above justifies that the use of [PRODUCT Name] is medically appropriate and necessary for [Patient Name]. [Enclosed is a copy of (Patient Name)’s medical records].

I request that you please approve coverage of [PRODUCT Name] for [Patient Name] as recommended. I appreciate your prompt consideration of this matter. If additional information is needed, I am happy to provide it to you.

Sincerely,

[Physician Name]

[NPI Number]

[Practice Name (if applicable)]

[Address]

[Phone Number]

[Fax Number]